Instructions for completing the Traumatic Brain Injury Registry Referral Form

Arkansas Statute 20-14-703 requires that every public and private health agency, public and private social agency, and attending physician report persons who have sustained a moderate-to-severe brain injury to the Brain Injury Alliance of Arkansas (BIAA) within five (5) days of injury identification or diagnosis. The BIAA has signed an agreement with the Arkansas Spinal Cord Commission (ASCC) Trauma Rehabilitation Program to assume responsibility for the Traumatic Brain Injury Registry.

Criteria for Referral: A brain injury must be reported to the TBI registry if Glasgow Coma Scale score is 12 or below for adults or 13 or below for pediatric patients. Do not report if the (adult) Glasgow score is 13 or above, the patient is not an Arkansas resident, or the injury is not the result of a traumatic injury.

Due to a patient's unstable medical status, some information may not be obtainable immediately. However, it is still the responsibility of the reporting person/facility to provide the missing information as soon as possible.

Note to Hospital and Rehabilitation facility personnel completing this form: Please use the boldface responses recommended in the "Response(s) Needed" section. All categories must be completed.

If you have any questions while completing this form, please call or email the Arkansas Trauma Rehabilitation Program Health Educator at (501) 683-3435 or atrp.info@arkansas.gov.

PATIENT/CLIENT REFERRAL INFORMATION	RESPONSE(S) NEEDED
Referral Date	Enter the date the referral is faxed or sent to the TBI Registry. Date format **MM/DD/YYYY**.
Survive To Acute	Was the individual admitted to acute care? Check either **Yes** or **No**.
Trauma Band Number	Enter the individual's Arkansas Trauma System **trauma band number**.
Payor Source	Enter the form of payment by the individual using the following terms: **Medicaid** **Medicare** **Medicaid/Medicare** **Not insured** **Worker's Compensation** **Private insurance** (please specify insurer)
Last Name **First Name** **M.I.**	Enter **last name**, **first name**, and **middle initial**. Suffixes such as Jr. or III should be entered with the last name, separated by a comma (for example, **Smith, Jr.**).
Address	Enter the individual's **residential street address**. Use Post Office Box addresses *only* when the residential street address is unknown.
City	Enter the name of the city where the individual resides. If the individual resides in another state, **do not refer to the registry.**
Zip Code	Enter the **Zip Code** of the individual's residence.
County	Enter the **county** where the individual resides.
Phone	Enter the **area code and phone number** for the individual.
Date of Birth	Date format **MM/DD/YYYY**.
Gender	Enter **M** for male or **F** for female.
Race	Enter one of the following: **A**-Asian **B**-African American/Black **I**-American Indian/Alaskan Native **L**-Hispanic/Latino **O**-Other **P**-Native Hawaiian/Pacific Islander **U**-Unknown **W**-White

Hispanic	Enter one of the following: **1** – if the individual **is** of Hispanic origin. **2** – if the individual **is not** of Hispanic origin.
Primary Contact / Legal Guardian Name	Enter the name of the responsible party / legal guardian who can be contacted in the daytime regarding the individual. When unknown, enter **"None."**
Phone (Primary Contact / Legal Guardian Phone Number)	Enter the **area code and phone number** where the primary contact or legal guardian can be reached during business hours.
Relationship	Enter the selection that best describes the relationship between the Primary Contact or Legal Guardian and the individual: Aunt, Brother, Brother-in-law. Daughter, Daughter-in-law, Ex-spouse, Facility contact, Father-in-law, Foster parent, Friend, Granddaughter, Grandparent, Grandson, Insurance agent, Legal guardian, Mother-in-law, Niece, Neighbor, Nephew, Other family member, Other official, Parent, Physician, School contact, Significant other, Sister, Sister-in-law, Social worker, Son, Son-in-law, Spouse, Spouse-separated from, Teacher, Uncle, Unknown
TBI Resource Packet	Enter the date the Primary Contact is provided with the TBI Resource Packet. Date format **MM/DD/YYYY**. Please distribute TBI Referral Packets ONLY to patients who meet the medical criteria for referral.
Reporting Facility	Enter the name of the facility (if applicable) reporting to the TBI Registry. Spell out the name of the facility as much as is possible (for example, **UAMS Medical Center**).
Reporter Name	Enter the name of the person in the facility that is responsible for making referrals to the TBI Registry. This person may need to be contacted by Trauma Rehabilitation Program with requests for missing or additional information. If a private citizen is making the referral, enter **N/A. Please write legibly.**
Reporter's Phone and Email Address	Enter the **area code, phone number, and extension (if applicable),** and **email address** of the person in the facility that is responsible for making referrals to the TBI Registry. This person may need to be contacted by Arkansas Trauma Rehabilitation Program with requests for missing or additional information. If a private citizen is making the referral, enter **N/A.**
Date of Injury	Enter the date the injury to the individual occurred. Date format **MM/DD/YYYY**
Time	Enter the approximate time the injury occurred, or when the individual was admitted to the facility. Hospital/rehab facility personnel completing this form should enter a number **01 through 12** to indicate the approximate hour of injury or admission **if it occurred at or before noon**. Enter a number **13 through 23** if the approximate hour of injury or admission occurred between **1:00 p.m. and 11:59 p.m.** Enter **00** if the approximate hour of injury or admission occurred between **12:00 a.m. to 12:59 a.m.** (Midnight.)
E-Code Location	Select the approximate location of where the injury occurred. If unknown, leave blank: **Home** — **Street or Highway** **Farm** — **Public Building** **Mine and Quarry** — **Residential Institution** **Industrial Place or Premises** — **Other Specified Place** **Place for Recreation or Sport** — **Unspecified Place**
Injury County	Enter the **county** where the injury occurred. If unknown, leave blank.

ETOH/Drug (Alcohol)	Enter the selection that best describes if alcohol or drug use was involved at the time of the injury: **1** – Not alcohol or drug related **2** – Alcohol related **3** – Drug related **4** – Alcohol and drug related **5** – Unknown
Protection	Enter the selection that best describes if safety devices were being used at the time of injury: **20** – 2 point belt (lap belt only) **21** – 3 point belt (shoulder and lap belt only) **22** – Airbags (air bag only) **23** – Airbags & Belt (airbag and seatbelt) **24** – Airbag deployed **25** – Car seat (infant/child car seat) **26** – Eye protection **27** – Hard hat **28** – Helmet **29** – None **30** – Padding **31** – Protective clothing **32** – Seatbelt (seatbelt only) **33** – Not recorded (default) **34** – Not performed **35** – Not available
Position	Enter the selection that best describes the position of the individual if the injury involved a motor vehicle: **1** – Driver/Operator **2** – Passenger **4** – Pedestrian **5** – Motorcycle Driver **6** – Motorcycle Passenger **7** – Other Specified **8** – Other/Cyclist **9** – Riding on Animal **10** – Streetcar Occupant **11** – Not Available
Etiology (Circumstances)	Enter the selection that best describes the cause of the individual's injury: **11** – Auto/Truck Accident **12** – Motorcycle Accident **13** – ATV/Moped/Dirt bike/Go cart **14** – Bicycle/Auto collision **15** – Bicycle/Not-auto collision **16** – Fall from Auto/Truck **17** – Boating/Jet Ski **18** – Heavy Equipment (farm/construction) **20** – Pedestrian/Auto collision **21** – Pedestrian/Bicycle collision **29** – Pedestrian unknown **31** – Stabbing **32** – Firearms **40** – Swimming **41** – Diving into a pool **42** – Diving into a natural body of water **44** – Football/Soccer/Hockey **45** – Skating/Skateboard/Scooter **49** – Other Sport **50** – Jump/Fall **55** – Falling Object **60** – Medical Complication **65** – Airplane/Train Crash **70** – Altercation/Assault **71** – Suspected Abuse **72** – Domestic Violence **73** – Car Surfing **74** – War Injury **98** – Other **99** – Unknown
Injury	Please indicate if the injury was **Accidental** or **Intentional**, **Self-Inflicted** or **Caused by another person or circumstance**. Please check all that apply.
Date of Admission	Date Individual was admitted to the facility, if applicable. Date format: **MM/DD/YYYY**
Date Brain Injury and/or Spinal Cord Injury Identified	Date the individual's brain injury was identified or diagnosed. This date may differ from the Date of Admission. Date format: **MM/DD/YYYY**

BRAIN INJURY INFORMATION

Glasgow Score To be collected: • Upon admission • At discharge.	The Glasgow Coma Score is vital information that must be on the form in order for the referral to be properly entered into the TBI Registry. Enter a number from 03 to 15 that best describes the individual's ability to respond. If the Glasgow Score is unknown or unavailable, it can be calculated using the included Glasgow Coma Scale Worksheet.
Open / Closed	Indicate if the individual's brain injury was **open** or **closed**.
Altered Sensorium	Indicate if the individual's senses (taste, touch, sight, hearing, or smell) have been affected by the brain injury by checking **Yes** or **No**.
Ventilator	Indicate if the individual required a ventilator to breathe by checking **Yes** or **No**.
ICD-9 Codes	Enter the codes that best describe the individual's brain (head) injury: **800** Fracture of the vault of the skull, including frontal parietal bones. **801** Fracture of the base of the skull. **803** Other unqualified skull fractures. **804** Multiple fractures involving skull or face with other bones **850** Concussion **851** Cerebral laceration & contusion **852** Subarachnoid, subdural, and extradural hemorrhage following injury **854** Intracranial injury of other and unspecified nature
Discharge Disposition (Please record the date of all discharge dispositions, including death.)	**0** – Another Acute Care Facility **1** – Home, Self Care **2** – Home, Non-Skilled Assistance **3** – Home, With Skilled Care **4** – Residential Facility Without Skilled Care **5** – Residential Facility With Skilled Care **6** – Inpatient Rehabilitation Facility **7** – AMA (Against Medical Advice) **8** – Hospice Care **9** – Deceased **10** – Other (please specify) **11** – Unknown
Discharge Facility	If the patient is transferred or discharged to another acute care facility or rehabilitation unit at another hospital, please indicate that facility.

SPINAL CORD INJURY INFORMATION

Para/Quad Level	Enter the level that best describes the individual's spinal cord injury: Cervical: **C1, C2, C3, C4, C5, C6, C7, or C8** Thoracic: **T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, or T12** Lumbar: **L1, L2, L3, L4, or L5** Sacral: **S1, S2, S3, S4, of S5**
Extent of Lesion	Enter the appropriate response that best describes the individual's spinal cord injury: **C** Complete loss of motor and/or sensory functions below the zone of injury. **I** Incomplete loss of motor and/or sensory functions below the zone of injury (includes sacral sensory sparing). **U** Unknown loss of motor and/or sensory functions below the zone of injury.
Ventilator	Check **Yes** or **No** to indicate if the individual requires a ventilator to breathe.
Sensory Deficit	Check **Yes** of **No** to indicate if the individual is experiencing sensory deficits as a result of the spinal cord injury.
Motor Deficit	Check **Yes** or **No** to indicate if the individual is experiencing motor deficits as a result of the spinal cord injury.
Bowel Deficit (Loss of control)	Check **Yes** or **No** to indicate if the individual is experiencing a loss of bowel control as a result of the spinal cord injury.
Bladder Deficit (Loss of control)	Check **Yes** or **No** to indicate if the individual is experiencing a loss of bladder control as a result of the spinal cord injury.
ICD-9 Codes	**342** Hemiplegia, if there is cord injury involved (paralysis of one side; right or left) **344** Paralytic Syndrome, if secondary to cord injury **806** Fracture of vertebral column with spinal cord injury **952** Spinal cord injury without evidence of spinal bone injury. Must involve three of the following deficits: sensory, bowel, bladder, or motor.

GLASGOW COMA SCALE

(Recommended for Age 4 to Adult)

Eye Opening	Points	Best Verbal Response	Points	Best Motor Response	Points
Spontaneous Indicates arousal mechanisms in brainstem are active.	4	***Oriented*** Patient knows who and where he or she is, and the year, season and month.	5	***Obeys Commands*** *Note: a gasp reflex or a change in posture does not count as a response.	6
To Sound Eyes open to any sound stimulus.	3	***Confused*** Responses to questions indicate varying degrees of confusion and disorientation.	4	***Localized*** Moves a limb to attempt to remove a painful stimulus.	5
To Pain Apply stimulus to limbs, not face.	2	***Inappropriate*** Speech is intelligible, but sustained conversation is not possible.	3	***Flexor: Normal*** Entire shoulder or arm is flexed in response to painful stimuli.	4
No Response	1	***Incomprehensible*** Unintelligible sounds such as moans and groans are made.	2	***Flexion: Abnormal*** The patient is rigidly still with arms flexed, fists clenched, and legs extended.	3
Choose the number from the column above that best describes patient's response. Enter here:		***No Response***	1	***Extension*** Abnormal turning and rotation of the arms and shoulders.	2
		Choose the number from the column above that best describes patient's response. Enter here:		***No Response***	1
				Choose the number from the column above that best describes patient's response. Enter here:	
				The Glasgow Score is the total of the three numbers chosen above. Enter total here:	